PROGENY

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Obstetric High Risk Legal Situations: What can nurses do to decrease liability?

As the Perinatal Team travels the state, we often address areas of concern that we see as high risk for medical-legal liability. Dr. Stephen Hunter, Maternal-Fetal Medicine Specialist and Associate Director of the Statewide Perinatal Care Program, has categorized the five areas where the majority of malpractice cases fall in the state. The five areas being: fetal heart rate tracings, Oxytocin and Cytotec, VBAC, shoulder dystocia, and operative vaginal deliveries (forceps and vacuums). In this issue and subsequent issues of Progeny, we are going to address what we as bedside nurses can do to decrease liability in these areas.

Fetal Heart Rate Tracings

- ***Use the terminology recommended by the National Institute of Child Health and Human Development (NICHD).*** This language has been adopted by ACOG, AWHONN, and other professional societies.
- ***Monitor continuously if possible or intermittently during labor epidural/spinal placement.***
- ***Recognize fetal vs. maternal heart rate.*** During our chart review we frequently see the maternal heart rate mistakenly being interpreted as the fetal heart rate with the external monitor in place. This usually occurs in the second stage of labor and continues for hours in some instances. Verify the fetal heart rate by placing a FSE, checking the maternal pulse, or placing the pulse oximeter on the mother. This will ensure accurate monitoring of the fetal heart rate. Recognizing the pattern when the maternal heart rate is being traced will also ensure correct identification of the fetal heart rate. (See Figure 1)
- ***Continue fetal monitoring in the OR.*** It is important to continue to assess fetal well-being during the preparatory period following spinal/epidural anesthesia in the OR. If using external fetal monitoring, monitor up to the time of the abdominal prep. The prep should take place when all members of the team are ready to proceed with the surgery. If a FSE is in place, it *may* be left in place

until just prior to delivery of the fetus through the hysterotomy (discuss this with your providers). In some hospitals where anesthesia personnel and the surgical team are not immediately available, a considerable amount of time may pass between discontinuing fetal monitoring in the labor room and actual delivery of the fetus. Fetal monitoring should be continuous during this period. This will decrease the time of non-monitoring to a minimum and allow for timely recognition of fetal distress should it develop.

- ***Establish a clear and agreed upon definition of fetal well-being***. For example: accelerations 15 beats per minute above the baseline lasting for 15 seconds for a term fetus; a baseline rate within normal limits (110-160 bpm); moderate variability ; and no recurrent late, variable, or prolonged decelerations present. Document fetal well-being on admission, prior to administration of pharmacologic agents for cervical ripening and labor induction, initiation of epidural analgesia, and on discharge (AWHONN *Perinatal Nursing* 3rd edition).
- ***Establish common interventions for intrauterine resuscitation***: maternal repositioning, an intravenous fluid bolus of at least 500 ml of LR, oxygen administered at 10 L/min via NR facemask, correction of maternal hypotension, and reduction of uterine activity, based on the FHR pattern (ACOG, 2005; Simpson & James, 2005b).

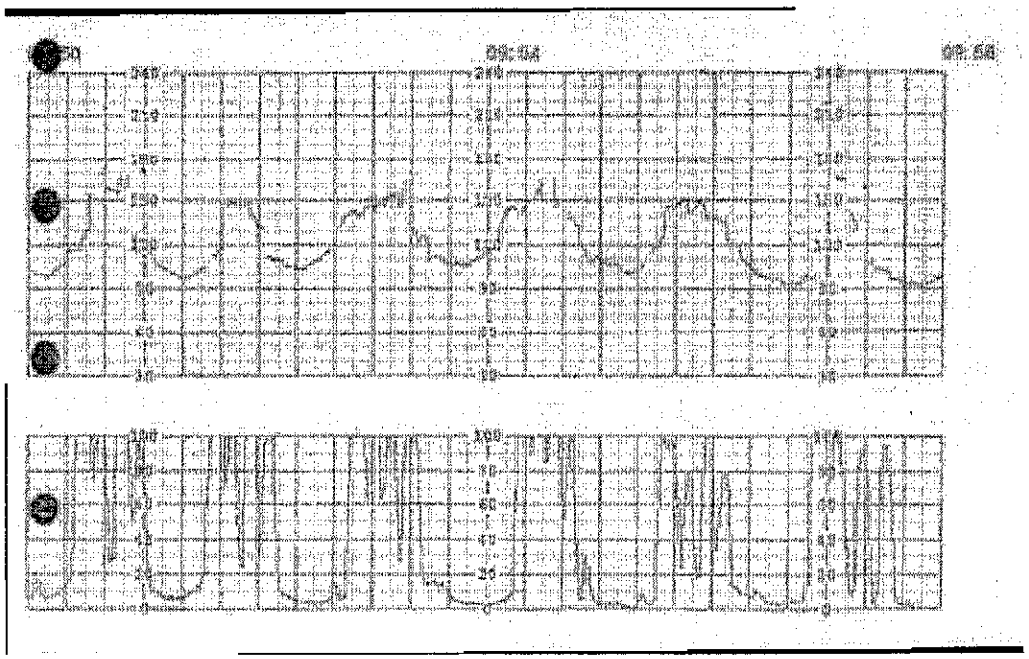

Figure 1

~ Amy N. Sanborn, RNC, BSN

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